WHO'S WHO IN THE MEDICAID PROGRAM

What is Medicaid

Title XIX of the Social Security Act (Medicaid) is a medical assistance program administered by the Division of Medical Assistance for certain low-income individuals and families. DMA contracts with EDS to process Medicaid claims for payment and to perform administrative tasks.

Eligible recipients receive medical care from providers enrolled in the program who then bill Medicaid for services. Updated coverage information and changes are issued in monthly Medicaid bulletins and through provider visits and seminars. Medical coverage information and Medicaid bulletins are available on DMA's website at **http://www.dhhs.state.nc.us/dma/prov.htm**.

Centers for Medicare and Medicaid Services

The Centers for Medicare and Medicaid Services (CMS) is the federal agency that regulates and oversees all state Medicaid programs. In addition, CMS is responsible for enforcing the transaction and code set standards that are part of the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Department of Health and Human Services

The N.C. Department of Health and Human Services (DHHS) oversees the administration of numerous health care programs in the State of North Carolina including Medicaid.

Division of Medical Assistance

The N.C. Division of Medical Assistance (DMA) is the state agency that administers the N.C. Medicaid program by:

- interpreting federal laws and regulations as they relate to the Medicaid program
- establishing clinical policy
- establishing all fees and rates
- establishing provider enrollment requirements
- maintaining provider files
- maintaining third party insurance files
- maintaining the Eligibility Information System
- enrolling all qualified North Carolina Medicaid providers
- administering Medicaid Managed Care programs
- publishing clinical policy
- publishing Medicaid bulletins

Department of Social Services

Each county department of social services (DSS) is responsible for:

- determining recipient eligibility for Medicaid
- enrolling and educating recipients about Managed Care programs
- maintaining all recipient eligibility files
- providing adult care home (ACH) enhanced care prior approval and case management services

Electronic Data Systems

Electronic Data Systems (EDS) is the fiscal agent contracted by DMA to:

- process claims for enrolled Medicaid providers according to DMA's policies and guidelines
- establish and maintain a presence with the Medicaid provider community through:
  - provider seminars
  - onsite visits to providers for assistance with billing issues

DIVISION OF MEDICAL ASSISTANCE ORGANIZATION ROLES

DMA is the state agency responsible for the administration of the N.C. Medicaid program. DMA is organized into six administrative sections with responsibilities as outlined below.

Recipient and Provider Services

The Recipient and Provider Services section is responsible for establishing recipient eligibility policy and maintaining the Eligibility Information System (EIS). This section is also responsible for provider enrollment, claims analysis, time limit overrides and provider education. This unit works closely with EDS provider services and monitors activities such as seminar planning, provider visits, and Medicaid bulletins. DMA Field Staff provides management consultation and technical assistance to county DSS staff and are responsible for training DSS staff on eligibility and EIS issues.

Clinical Policy and Programs

The Clinical Policy and Programs section is responsible for the overall administration of programs and clinical services covered by the N.C. Medicaid Program. The Clinical Policy and Programs section establishes policies and procedures for the provision of all Medicaid covered services.

Clinical Policy Development and Technical Support

The Clinical Policy Development and Technical Support unit is responsible for:

- assuring compliance with Session Law 2004-124 to develop clinical coverage policies according to national or evidence-based standards
- obtaining the advice of the N.C. Physician's Advisory Group
- following a prescribed process for provider/public comment on proposed policies
- routinely reviewing and updating clinical coverage policies based on changes in medical practice and literature
- policy evaluations of efficacy, fiscal impact, utilization, and population analyses

Managed Care

The Managed Care section is responsible for the administration of the Community Care of North Carolina (CCNC) program (Carolina ACCESS (CA) and ACCESS II/III) and HMO Risk Contracting. (Refer to **Managed Care Provider Information** on page 4-1 for additional information on Managed Care providers.)

This activity includes:

- the development and implementation of Managed Care policy
- recruiting and educating providers to participate as primary care providers (PCPs)
- furnishing technical assistance to providers
- assisting the medical community to understand Managed Care programs
- the development of ACCESS II/III in conjunction with the Office of Research, Demonstration, and Rural Health Development
- monitoring contractual compliance
- Staffing the Recipient Hotline

Quality Management

Quality Management is responsible for ensuring that the care provided within each of the Medicaid Managed Care programs is of acceptable quality, accessibility, continuity, and efficiency. Activities include utilization monitoring, assessment of patient satisfaction, complaint monitoring, focused care studies, physician collaborations, report development, and quality improvement projects.

Piedmont Cardinal Health Plan

If the recipient is enrolled in the Piedmont Cardinal Health Plan, the letters "PCHP" are printed on the card. If the recipient is enrolled in the Innovations plan, both "PCHP" and "CM" or simply "CM" are printed on the card. All behavioral health services for recipients participating in PCHP or CM or both must be approved by PCHP in order for the provider to be reimbursed.

Finance Management

This organization is comprised of Information Services, Rate Setting, Hospital Reimbursement and Audit organizations. Activities and responsibilities are as follows:

Information Services

The Information Services section is responsible for the automation resources/functionality of DMA, which is maintained either in-house or by contract. This section is divided into the Contract Monitoring unit, the Medicaid Management Information Services (MMIS) unit, the Information Center unit, and Decision Support unit.

Rate Setting

The Rate Setting section is responsible for establishing and maintaining reimbursement policy and payment rates for all Medicaid providers and payment programs with the exception of hospital providers and calculating the fiscal impact of proposed and approved rate changes.

Hospital Reimbursement

The Hospital Reimbursement organization is responsible for establishing and maintaining reimbursement policy and inpatient/outpatient payment rates to hospital providers, as well as administration of the Disproportionate Share Hospital (DSH) payment program.

Audit

The Audit section is responsible for cost settling and auditing cost reports from various provider types and organizations, including long-term care, hospital, Federally Qualified Heath Clinics, Rural Health Centers, and Local Health Departments.

Budget Management

The objectives of the Budget Management Unit are to accurately project category of service expenditures by category of eligibility, changes in eligibility and the rate of consumption of units of services. Because the DMA Budget is the largest budget in DHHS, it has high visibility in the Department as well as over the whole State. A 1% error in projections regarding the total budgeted requirements could create an impact of up to $95 Million Dollars. This unit responds to and prepares all requested fiscal analyses used by the General Assembly when considering reduction/expansion options for the biennial budget. This unit has responsibility for documenting the Medicaid forecasting model, performing trend analysis on key factors driving the Medicaid Budget, researching and developing data to support decision-making on budget assumptions, and producing multi-year forecasts.

Much of the business of the Medicaid and NC Health Choice for Children programs is conducted through contractual agreements, including multiple contracts with the same provider. Total Contract expenditures are expected to reach $80 Million Dollars this year. Budget Management is responsible for assuring that

adequate and reasonable payments are made to medical providers on behalf of the Medicaid eligible clients. This unit forecasts the budgetary requirements of the program to assure federal, state and county funds are available to support program payments, maximizing the use of revenues, and approval of all financial policies. All contracts and agreements with outside vendors are developed, approved, maintained, and monitored by this unit.

The Budget Management Unit works closely with the fiscal intermediary to resolve provider as well as payment issues. This unit creates the annual Checkwrite Schedule in conjunction with the DHHS Controller's Office as well as the fiscal agent. They also maintain correspondence with providers who may have questions or issues with payments.

This unit ensures that all general accounting functions are maintained; such as, vendor payments for general operating expenses, accurate financial analyses and reporting, as set by Generally Accepted Accounting Practices, the State Auditor, as well as established Comprehensive Annual Financial Reporting guidelines established within the State of NC.

Program Integrity

Program Integrity (PI) ensures that:

- Medicaid dollars are paid correctly by identifying overpayments to providers and recipients occurring due to error, abuse or fraud.
- Overpayments are recovered and the proper agencies are informed of any potentially fraudulent actions.
- Recipients' rights are protected and recipients receive quality care.
- Problems are communicated to appropriate staff, providers or recipients and corrected through education and changes to the policy, procedure or process, and are monitored for corrective action.

PI achieves this by:

- conducting post-payment reviews of:
  - provider billing practices and cost reports
  - claims paid by the fiscal agent
  - recipient eligibility determinations
- identifying overpayments for recoupment
- identifying medical, administrative, and reimbursement policies or procedures that need to be changed
- educating providers on their errors
- assessing the quality of care for Medicaid recipients
- assuring Medicaid pays for only medically necessary services
- identifying and referring suspected Medicaid fraud cases to the Attorney General's Office, Medicaid Investigation Unit, other state agencies, professional boards (e.g., boards of pharmacy, dentistry, etc.) or to federal agencies for investigations (e.g., Drug Enforcement Agency)
- overseeing recipient fraud and abuse activities by the local county department of social services (DSS) to assure that recipient overpayments are recouped